NEW HORIZONS WELLNESS CENTER & MEDISPA

Title: _____ First:_____ Middle:_____ Last: _____

DOB: _____ Gender: _____ SSN: _____

Referral Information Marital Status: _____ Ethnicity: _____

Referral Source: _____

Race: _____ Preferred Language: _____

Preferred Local Pharmacy: _____Preferred Compounding Pharmacy: _____

Contact Information

Address:_____ Apt: _____ City:_____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ Cell Phone Carrier: _____

Email Address: _____

Occupation: _____ Work Phone: _____

Emergency Contact Information

Relationship: _____

Last Name:_____ First Name: _____Nick Name:_____

Home Phone: _____ Work: _____ Cell: _____

Preferred Method	Okay to leave voicemail?	Okay to leave message with another person?	Best Time to Call
☐ Call Work Number	☐	☐	□ Morning □ Afternoon □ Evening
☐ Call Cell Phone	☐	☐	□ Morning □ Afternoon □ Evening
☐ Call Home Number	☐	☐	□ Morning □ Afternoon □ Evening
☐ Send Email	☐ Ok for my appointment reminder? ☐ Ok for Medical/Schedule Info		☐ Ok for special offers?

☐ Send Regular Mail Mail-To: _____

☐ Send Text ☐ Ok for my appointment reminder? ☐ Ok for Medical/Schedule Info ☐ Ok for special offers?

If it's okay to leave a message with another person please indicate:

Relationship: _____ Name: _____

Contact Number:_____

Consent to use photos

☐ Medical ☐ Office ☐ Internet Date of Consent: _____ Photo Limitation: _____

NEW HORIZONS WELLNESS CENTER & MEDISPA

Insurance Information

Responsible Party: ☐ *Self* ☐ *Spouse* ☐ *Parent* ☐ *Other*

Primary Insurance: _____ Policy # _____ Group: _____

Responsible Party: ☐ *Self* ☐ *Spouse* ☐ *Parent* ☐ *Other*

Secondary Insurance: _____ Policy # _____ Group: _____

I _____ have insurance coverage and assign all medical benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the provider at New Horizons Wellness Center to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions.

_____ _____

Signature of Insured/Guardian Date

HIPAA Information and Consent Form

The Health Insurance Portability and Accountability Act (HIPAA) provides safeguards to protect your privacy. Implementation of HIPAA requirements officially began on April 14, 2003. Many of the policies have been *our* practice for years. This form is a "friendly" version. A more complete text is posted in the office.

What this is all about: Specifically, there are rules and restrictions on who may see or be notified of your Protected Health Information (PHI). These restrictions do not include the normal interchange of information necessary to provide you with office services. HIPAA provides certain rights and protections to you as the patient. We balance these needs with our goal of providing you with quality professional service and care. Additional information is available from the U.S. Department of Health and Human Services. www.hhs.gov

We have adopted the following policies:

1. Patient information will be kept confidential except as is necessary to provide services or to ensure that all administrative matters related to your care are handled appropriately. This specifically includes the sharing of information with other healthcare providers, laboratories, health insurance payers as is necessary and appropriate for your care. Patient files may be stored in open file racks and will not contain any coding which identifies a patient's condition or information which is not already a matter of public record. The normal course of providing care means that such records may be left, at least temporarily, in administrative areas such as the front office, examination room, etc. Those records will not be available to persons other than office staff. You agree to the normal procedures utilized within the office for the handling of charts, patient records, PHI and other documents or information.
2. It is the policy of this office to remind patients of their appointments. We may do this by telephone, e-mail, U.S mail, or by any means convenient for the practice and/or as requested by you. We may send you other communications informing you of changes to office policy and new technology that you might find valuable or informative.
3. The practice utilizes a number of vendors in the conduct of business. These vendors may have access to PHI but must agree to abide by the confidentiality rules of HIPAA.
4. You understand and agree to inspections of the office and review of documents which may include PHI by government agencies or insurance payers in normal performance of their duties.
5. You agree to bring any concerns or complaints regarding privacy to the attention of the office manager or the doctor.
6. Your confidential information will not be used for the purposes of marketing or advertising of products, goods or services.
7. We agree to provide patients with access to their records in accordance with state and federal laws.
8. We may change, add, delete or modify any of these provisions to better serve the needs of the both the practice and the patient.
9. You have the right to request restrictions in the use of your protected health information and to request change in certain policies used within the office concerning your PHI. However, we are not obligated to alter internal policies to conform to your request.

I _____ do hereby consent and acknowledge my agreement to the terms set forth in the HIPAA Information Form and any subsequent changes if office policy. I understand that this consent shall remain in force from this time forward.

Signature: _____ Date: _____

My initials below constitutes my acknowledgement of:

Statement of Patient Financial Responsibility ***(Initials _____)***

New Horizons Wellness Center and MediSpa appreciates the confidence you have shown in choosing us to provide for your health care needs. The service you have elected to participate in implies a financial responsibility on your part. As a courtesy, we will verify your coverage and bill your insurance carrier on your behalf. However, you are ultimately responsible for payment of your bill.

You are responsible for payment of any deductible and co-payment/co-insurance as determined by your contract with your insurance carrier. We expect these payments at time of service. You are responsible for any amounts not covered by your insurer.

I have read the above policy regarding my financial responsibility to NHWC, for providing services to me or the above named patient. I certify that the information is, to the best of my knowledge, true and accurate. I authorize my insurer to pay any benefits directly to New Horizons Wellness Center & MediSpa.

Consent for Treatment and Authorization to Release Information ***(Initials _____)***

I hereby authorize New Horizons Wellness Center and MediSpa, through its appropriate personnel, to perform or have performed upon me, or the above named patient, appropriate assessment and treatment procedures.I further authorize New Horizons Wellness Center, to release to appropriate agencies, any information acquired in the course of my or the above named patient's examination and treatment.

Self-Pay or Co-Pay ***(Initials _____)***

If I do not have health insurance, I will not be responsible for services rendered here at New Horizons Wellness Center & MediSpa. I agree to pay NHWC the full and entire amount of treatment given to me or to the above named patient at each visit. If I have insurance, I am responsible for the co-pay and/or deductible amount at the time of services rendered.

Receipt of Notice of Privacy Practices ***(Initials _____)***

I acknowledge that I have received notification of the Privacy Practices of New Horizons Wellness Center.

Confidential Communication

I, _____, hereby authorize release of information regarding my medical condition to the person named below. I hereby give permission to New Horizons Wellness Center through its medical providers and staff to release to my designee any information about my medical condition or the status of my account, and I release New Horizons Wellness Center & MediSpa, its medical providers and staff from any claim of confidentiality in connection with the release of this information.

Name of Designated Person: _____
Relationship: _____ Phone Number _____ (home/work/cell)
Patient/Guarantor Signature: _____
Date: _____

I decline to designate another person to speak with my physician or clinical staff.
Patient/Guarantor Signature: _____
Date: _____

NEW HORIZONS
WELLNESS CENTER
& MEDISPA

Patient Roles and Responsibilities

As a patient, you are responsible to:

You must provide accurate and complete information about your present complaints, past illnesses, hospitalizations, medications and other health care matters. Please make sure to update any changes to your phone number and demographic information at our front desk.

You must promptly meet any agreed financial obligation at each visit. I understand that payment is due at time of service.

If you fail to pay any insurance payments/balance due after our submission to your carrier, our physician/patient relationship will be effective in 30 days from the notice of payment warranted.

I understand that if I show up late to my scheduled appointment I will now be considered a Walk-In and will be seen around scheduled appointments.

You must follow your care, treatment and service plan. I understand that all prescriptions, including refills, require an office visit unless otherwise noted by the provider.

I understand that all routine follow ups, including but not limited to, lab results, injections and medication changes require an office visit and will not be discussed via telephone unless otherwise noted by the provider.

You must follow our practice rules and regulations including the practice safety regulations and its "no smoking" policy. Please silence your cell phones during your visit with us and refrain from usage after entering our suites for services.

I certify that I have read this entire informed consent. I understand and agree to the information stated in this form. I certify that I am a competent adult of at least 18 years of age.

Patient Signature:_____DOB: _____

Patient/Guardian Signature: _____Date: _____